MANAGING FOR RECOVERY • UNENDING PRICE WARS • INSIDE TIME WARNER

MARCH 23, 1992 $3.95

FORTUNE

HEALTH CARE

BUILDING THE SYSTEM WE NEED

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MARCH 23, 1992 VOL. 125, NO. 6

FORTUNE

POLITICS & POLICY/COVER STORY

ABOVE: At a clinic near Boston, prescriptions can be ready in three minutes with the help of computers. Photo by Richard Howard.

COVER: Computer software and HMOs are building blocks of a superior American medical system. Illustration by Theo Rudnak.

Continuous quality improvement—doing it for less *and* doing it better—is now the hot concept in the better-run parts of the health industry. 46

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For all its life-saving miracles, the U.S. medical system is distressingly wasteful and managerially backward. Costs won't stop climbing, and some 36 million Americans have no health insurance. But by taking advantage of the growing public pressure for universal health coverage and putting market forces to work, the U.S. can turn this out-of-control sector into the envy of the world. FORTUNE prescribes a four-step remedy. *by Edmund Faltermayer*

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EDITOR'S DESK

FORTUNE prides itself on tackling America's most pressing problems. In this issue we take on one of business's biggest headaches: the $800 billion health care mess. "Let's *Really* Cure the Health System," which begins on page 46, presents innovative strategies for turning the current flawed system into the world's most admired. Writer Edmund Faltermayer holds out considerable hope: "We can be the first industrial nation where market forces determine what's spent on health care, just as they determine what people spend on food, cars, and housing."

CARL RACO

Faltermayer and Berlin propose some innovative therapy.

This cover story is the culmination of Faltermayer's 22 years on the health care beat. In 1970 he published in FORTUNE one of the earliest major stories about HMOs. It helped pave the way for the passage of the first federal HMO act in 1972. Says Faltermayer: "Health care is a cause of mine. I am a soapbox journalist who believes there are some real cures for what ails us."

To find the solutions, Faltermayer and reporter Rosalind Berlin spent two months interviewing over 100 sources, including dozens of physicians, health care policy experts, representatives of health organizations and corporations, and employees. Says Richard Kirkland, who edited the article: "What distinguishes this story is that it is not just a policy piece; it discovers the best of what's going on among practitioners."

For example, Berlin spoke with employees at FORTUNE 500 companies who are participating in managed-care plans. Says she: "One frequent fear that people have about HMOs is that they won't be able to go to specialists. It was comforting to hear that in many cases members believed that they received a higher level of specialty care than they did with similar illnesses under their old medical plans." Berlin is no novice to the industry either. Her family tree is full of doctors, and this is her third story with Faltermayer.

The solutions in this article are particularly timely. Some 36 million Americans remain uninsured, and costs for businesses keep rising at a shockingly high rate. At last count there were over two dozen bills in Congress to reform the health care insurance system. Says Faltermayer, on his soapbox: "Things have gotten so bad that now we have a chance to do something good. It's particularly important in this election year as candidates prepare position papers that FORTUNE have something on the table."

Marshall Loeb

MANAGING EDITOR

FORTUNE (ISSN 0015-8259) Published biweekly, with three issues in October, by The Time Inc. Magazine Company. Principal office: Time & Life Building, Rockefeller Center, New York, NY 10020-1393. Reginald K. Brack Jr., President; Joseph A. Ripp, Treasurer; Mary M. Johnston, Secretary. Subscriptions: U.S., possessions, one year $27 issues, $50 two years, one year $27 issues, $53 Canada, one year $27 issues, $53 FX. Second class postage paid at New York, NY, and at additional mailing offices. Authorized as second class mail by the Post Office Dept., Ottawa, Canada, and for payment of postage in cash. Member, Audit Bureau of Circulations. POSTMASTER: Send address changes to FORTUNE, P.O. Box 30604, Tampa, Fla. 33630-0604. Customer inquiries: FORTUNE, P.O. Box 60001, Tampa, Fla. 33660-0001. Phone: 1-800-621-8000.
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The Time Inc. Magazine Company GST #R122781974.

EARNINGS NOSE-DIVE IN NIPPON

■ Japan Inc.'s record nonstop economic growth—the Heisei boom, named for the era of current Emperor Akihito and dating from December 1986—may be over. Industrial production is down 4% from last year, inventory is up 12%, and many of the country's corporate giants—including **Nippon Steel** and semiconductor manufacturers like **Toshiba**—are facing their weakest earnings since fiscal 1987. **Sony** is even forecasting a $156 million loss for its businesses in Japan, the first ever. Several other consumer electronics companies have announced big drops in their pretax earnings from worldwide operations for the 12 months ending March 31. That's when most Japanese companies end their fiscal year.

Japan's auto industry is also hurting. **Toyota Motor** has reported that it expects a 30% drop in pretax profits of its domestic operations, to $3.1 billion. Says Toyota executive VP Shohei Kurihara: "Americans may be discussing how the U.S. economy has declined relative to Japan's, but I think the Japanese economy isn't very healthy." Of course, Toyota and other automakers are still exploring new foreign markets (see following story).

Japanese corporations blame their profit declines partly on a stronger yen. They also say fierce price wars among themselves and with foreign manufacturers created sluggish sales. Sony's worldwide revenues, for example, rose just 5% to $30 billion.

Most Japanese companies are also stuck with high depreciation costs linked to a 64% nationwide increase in corporate capital investments over the past four years. Sony plans to reduce such spending by 36% to $2.2 billion next year, and other companies may try a similar strategy. Says Yoichi Tazawa of Nomura Research Institute: "The Japanese economy has been expanding beyond its means." Like others, Tazawa still expects some kind of recovery in the corporate sector by the end of 1992.

Not all companies are doing as badly. Among consumer electronics manufacturers, **Sharp** seems to be holding its own (for more, see Corporate Performance). – **Emily Thornton**

JAPANESE CARS INVADE ISRAEL

■ Whatever their image problems in the U.S., Japan's automakers need more customers and are speeding on to other frontiers. Their latest target: Israel. **Toyota Motor**, **Mazda**, **Daihatsu**, and **Suzuki** opened showrooms last year, joining **Honda** and **Mitsubishi**. Now **Isuzu** and **Nissan** are eyeing the market.

Oil-hungry Japan Inc. has been cautious about doing business with Israel since Arab petroleum suppliers temporarily stopped exporting to pro-Israel countries in the 1970s. A company that didn't duck for cover: **Fuji Heavy Industries**' Subaru car division, which exported to Israel despite the risks. As a result Subaru has some 30% of Israel's market.

The Japanese automakers' next foreign target? Predicts Keith Donaldson, Asia auto analyst for Salomon Brothers in Tokyo: a post-apartheid South Africa. – **E.T.**

A Tel Aviv showroom: sorry, no word on whether an armed customer gets a better deal

RECESSION-PROOF SUPERMODELS

■ While the rest of the world has been slogging through a recession, an elite group of women including Naomi Campbell, Cindy Crawford, Linda Evangelista, Christy Turlington, and Claudia Schiffer have proved immune to the downturn. These supermodels charge—and get—$10,000 a day and more. In advertising, says Monique Pillard, president of Elite modeling agency, which represents Crawford and Evangelista: "Supermodels are taking the place of movie stars because they're more accessible and more real to the public." Say what?

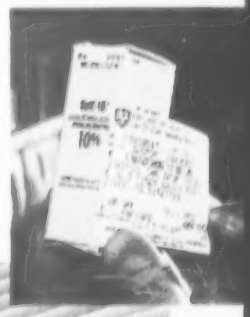
It helps that some supermodels become famous in their own right. Schiffer, back again on

LET'S *REALLY* CURE THE HEALTH SYSTEM

By seizing on the momentum for universal health coverage and putting market forces to work, the U.S. can turn an out-of-control sector into the envy of the world. ■ *by Edmund Faltermayer*

WHAT'S WRONG with U.S. health care? Angry voters and anxious politicians in this presidential election year are fingering two villains—costs that won't stop climbing and an insurance system that leaves 36 million Americans without coverage. But a third, though it gets less attention, is arguably the most important: For all its lifesaving miracles, most of the $800-billion-a-year U.S. medical system is as wasteful and managerially backward as Detroit before Henry Ford. The country's best hope for insuring everyone while keeping overall health spending within reason is to harness the growing public pressure for reform to a plan that could transform this flawed system into the Toyota City of world health care.

Only market forces, which drive and discipline most other sectors of the economy, can bring about this industrial revolution. Having faith that the market can curb total medical spending is like believing in heavier-than-air flying machines before Kitty Hawk, since no major country has relied exclusively on competition. It's also true that this new machine will fly only by forcing big changes upon patients, doctors, insurers, and bureaucrats. The model that FORTUNE favors would require nearly every American to enroll in a health maintenance organization (HMO) or a similar managed-care plan. These limit a patient's choice of doctor and hospital, though a growing number allow patients to go outside the network by paying extra.



On the frontier: Computers, like those at a Harvard Community Health Plan clinic near Boston, help Dr. Max Walten treat Caroline Abbot and order a prescription for her eye infection. It's ready within three minutes, complete with a computer-printed label (right).

But the present system is clearly unsustainable. Under traditional fee-for-service health insurance plans, doctors and hospitals, which patients are free to choose, get paid no matter how many services and tests they perform. That kind of economic rocket engine has propelled health spending from 7.3% of GNP in 1970 to a projected 13.4% in 1992. U.S. business's share of this bill—$186 billion in 1990—now exceeds its combined after-tax profits.

To keep the current system from crashing, the only alternative to market-based reform is to impose more controls. The two government-financed programs, Medicaid for the poor and Medicare for those 65 or over, already impose price ceilings—including a new 7,000-item revision in what doctors can charge for treating the elderly. With imperfect success, other countries with universal health coverage attempt to keep a lid on total expenditures through price fixing, spending caps, or a budgeting process like Canada's, in which provinces and the national government appropriate sums to reimburse providers. Some of the health reform plans proposed by congressional Democrats call for ceilings of one kind or another (see table).

By embracing controls at a time when the former Soviet Union is turning to the free market, the world's seventh-largest "economy"—the U.S. health care system—would be taking the Gosplan route. To some, greater government control is inevitable. How, they ask, can doctors and hospitals go on providing bone marrow transplants at $150,000 and intensive care for drug-damaged premature babies without Washington's limiting prices or setting up a rationing system?

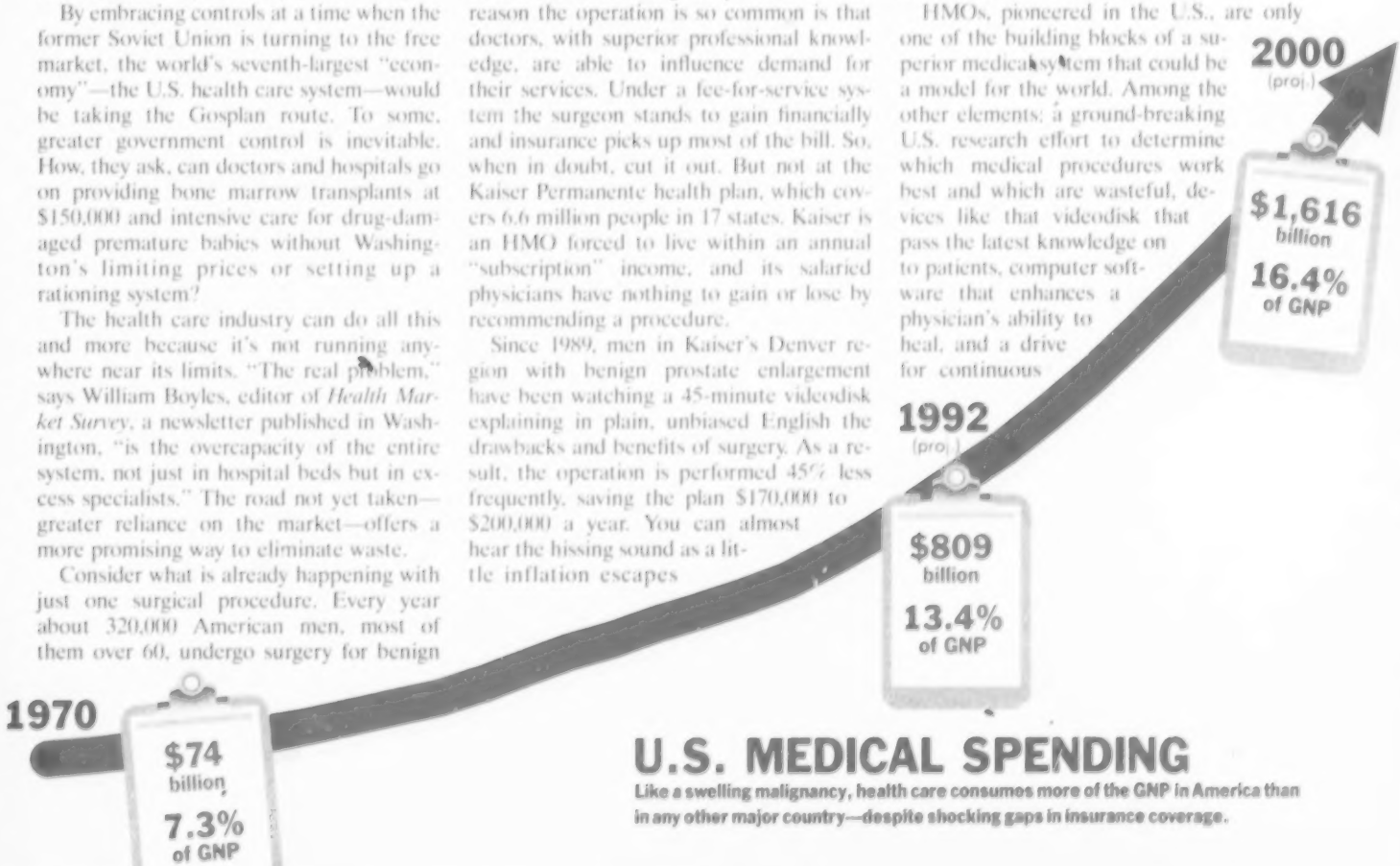
The health care industry can do all this and more because it's not running anywhere near its limits. "The real problem," says William Boyles, editor of *Health Market Survey*, a newsletter published in Washington, "is the overcapacity of the entire system, not just in hospital beds but in excess specialists." The road not yet taken—greater reliance on the market—offers a more promising way to eliminate waste.

Consider what is already happening with just one surgical procedure. Every year about 320,000 American men, most of them over 60, undergo surgery for benign enlargement of the prostate. This can easily cost $4,000, including hospital bills. One reason the operation is so common is that doctors, with superior professional knowledge, are able to influence demand for their services. Under a fee-for-service system the surgeon stands to gain financially and insurance picks up most of the bill. So, when in doubt, cut it out. But not at the Kaiser Permanente health plan, which covers 6.6 million people in 17 states. Kaiser is an HMO forced to live within an annual "subscription" income, and its salaried physicians have nothing to gain or lose by recommending a procedure.

Since 1989, men in Kaiser's Denver region with benign prostate enlargement have been watching a 45-minute videodisk explaining in plain, unbiased English the drawbacks and benefits of surgery. As a result, the operation is performed 45% less frequently, saving the plan $170,000 to $200,000 a year. You can almost hear the hissing sound as a little inflation escapes from the swollen balloon of American medical care.

HMOs, pioneered in the U.S., are only one of the building blocks of a superior medical system that could be a model for the world. Among the other elements: a ground-breaking U.S. research effort to determine which medical procedures work best and which are wasteful, devices like that videodisk that pass the latest knowledge on to patients, computer software that enhances a physician's ability to heal, and a drive for continuous

This computer at an Intermountain Health Care hospital in Salt Lake City delivers instant advice to an intensive care team. It may have saved MaRee Sullivan from ARDS, a deadly respiratory illness.



U.S. MEDICAL SPENDING

Like a swelling malignancy, health care consumes more of the GNP in America than in any other major country—despite shocking gaps in insurance coverage.

Doctors often forget about patients after treatment. Not orthopedist Jay Butler of Portland, Oregon, who checks Wilbur Jansen a year after a hip replacement as part of an effort to improve the procedure.

quality improvement. What's missing are the essential ingredients that would hasten the adoption of all that's being learned—bold policy changes aimed at fostering pervasive competition.

Here's a closer look at four strategies that together could cure U.S. health care:

■ **Find out what works.** In its latest annual report, the Harvard Community Health Plan, a Massachusetts HMO, observes that "as few as a third" of all medical ministrations—drugs, surgery, tests—have been shown scientifically to help cure disease or preserve health. Doctors aren't stupid, and many of the other remedies may indeed be effective. But rigorous proof is missing. "The information base for medical practice is extremely poor," declares Dr. David Eddy, a leading critic of that base. One sign, he says, is that your chances of getting a particular operation vary greatly from place to place. In one four-state survey, the frequency of heart bypass operations varied by a factor of three.

Prodded by employers frustrated over rising costs, insurance companies have tried to curb excesses through "utilization review." Computerized claims-review programs spot doctors whose tests and procedures deviate from observed patterns. Despite some successes, utilization review doesn't get to the heart of the problem. Only doctors can figure out better ways to treat patients. Partly in the hope of heading off further ham-handed controls, the medical profession is swinging behind what Eddy calls "an intellectual revolution" to clear up the uncertainties.

One way is through "outcomes management," a concept pioneered by Dr. Paul Ellwood and InterStudy, the Minneapolis research organization he heads. Ellwood believes the whole health system needs a "unified scorekeeping system." One day, he hopes, computer databanks will medically track everyone in the population, both at the time of treatment and afterward, to see which treatments are best for the patient in the long run.

Over the past four years, InterStudy and others have been testing standardized "score cards" for charting patients through 16 illnesses—among them diabetes, cataracts, and hypertension—and nine more are in the works. For each illness, doctors put down clinical information at the time of the encounter with the patient and later on. All patients, when getting treatment and afterward, fill out a general "health-status questionnaire."

Twenty thousand patients in 23 states have completed the form to date. Sample question: "Does your health limit you in climbing several flights of stairs?" The patient marks one of three boxes ranging from "a lot" to "not at all." The theory is that people's perceptions of their own health give clues that traditional doctor's questions may miss. Each disease, it has been found, leaves its own fingerprint in the pattern of answers, and the questionnaire can help *predict* illness.

For three years Dr. Jay Butler of St. Vincent's Hospital in Portland, Oregon, has been accumulating outcomes-management data on the hip replacements he performs. Follow-up visits by patients, he says, are giving him answers to such questions as "What's my batting average?" and "Am I doing it to the right people?" He's already decided that a high-tech ceramic coating, designed to speed the bonding of the artificial device to the patient's bones, isn't worth the potential bone erosion and the hundreds of extra dollars it costs. Other payoffs will come when outcomes-management data are shared over large regions. Minneapolis's Park Nicollet Medical Center is one of six clinics around the country that have just begun to swap outcomes data on hip replacement.

The government is financing another ambitious effort by doctors to cut down on guesswork. Only three years old, the Agency for Health Care Policy and Research, or AHCPR (pronounced "ak-par"), has a budget of $67 million a year for studying the appropriateness of treatments—far more than Washington used to spend.

AHCPR is financing 12 "patient outcomes research teams," or PORTs, that aim to get at the truth on alternative ways to deal with coronary artery disease, gallstones, pneumonia, diabetes, and pain in

REPORTER ASSOCIATE *Rosalind Klein Berlin*

the lower back , among others. Relying on a huge, 20-year-old database from Duke University's hospital and other records, the PORT on coronary artery disease hopes to be able to estimate, with considerable precision, the survival rates and cost-effectiveness of the remedies—heart bypass operations, balloon angioplasty, and medication—for this big-ticket illness.

Most of the PORTs' findings are several years off. But Dr. John Wennberg, who drummed up much of the support for AHCPR's creation, believes its efforts will produce "a leaner, trimmer health care economy." Wennberg, who heads Dartmouth University's Center for Evaluative Clinical Sciences, discovered in the early 1980s that Boston was spending the equivalent of 16% of local GNP on health care while New Haven, Connecticut, was spending only 9%, with no difference in the two populations' health. Outcomes research can't rationalize all medical care, Wennberg says. But it can create "islands of rationality in a sea of uncertainty and supplier-induced demand."

Low back pain, the No. 2 reason for physician visits after colds, needs all the rationality it can get. Medical spending to alleviate this torment totals about $24 billion a year, four times the cost of AIDS treatment. Much of the money is wasted; a mid-1980s study of Medicare patients found that 71% of nonsurgical hospitalizations for this affliction were unnecessary. Practice patterns vary wildly, especially for the most expensive form of surgery, in which two vertebrae are joined in a spinal fusion at $15,000 or so. In 1986 the operation was nine times as common in the West as in the Northeast, and it varies sevenfold by county just within the state of Washington.

Fertile territory, all right, for a PORT headed by the University of Washington's Dr. Richard Deyo. In the mid-1980s, Deyo and his colleagues punctured the age-old belief in long bed rest as a cure—good news for employers, who lose when workers stay home. Comparing two groups of patients who spent two and seven days in bed, respectively, Deyo found identical outcomes in terms of pain relief and return to normal function.

One issue the PORT is addressing, with the help of Medicare claims and hospital discharge data for thousands of cases, is the relative merit of spinal fusion vs. simpler back surgery, such as the partial removal of a disk. Fusion operations, according to Deyo, turn out to have complications twice as frequently as simpler surgery. One widely used argument for fusion, that it lessens the need for later operations, is not holding up. The claims data, Deyo says, show that those who get fused are "at least as likely" to have future problems.

■ **Inform the patient.** How many citizens whose backs are killing them might forgo the operation, and save the system money, if they knew this? Before long, some will. A videodisk on low back pain is scheduled to start appearing in doctor's offices this fall, along with one for women with early-stage breast cancer, another on mild hypertension, and an update of the prostate video. The programs are the brainchild of John Wennberg and his colleagues. Wennberg serves as vice chairman of their producer, the nonprofit Foundation for Informed Medical Decision Making, on the edge of the Dartmouth campus.

These videodisks are worlds ahead of the educational videotapes that have cropped

FIVE PATHS TO UNIVERSAL HEALTH INSURANCE

PLAN	HOW IT WORKS	WHO'S FOR IT	HOW IT WOULD LIMIT COSTS
Canadian-style system	A tax-supported, government-run system would pay all medical bills	Sixty-six Democratic Congressmen—and one Republican—led by Representative Russo (D-Illinois)	Government budgeting process
Play or pay	Employers would have to provide minimum health coverage or pay new taxes to finance a government-run plan	Democratic Senate leadership (Mitchell bill); Representative Rostenkowski in House	Payers and providers negotiate prices within national guidelines (Mitchell); government gradually limits rise in health spending to GNP growth rate (Rostenkowski)
President Bush's health plan	Tax credits up to $3,750 a year for low-income families and deductions for the middle class would help many of the uninsured buy basic health insurance	Bush Administration	Find offsetting efficiencies throughout the health care system
Consumer choice	Individuals would be required to buy health insurance on their own or through employers, paying with a proposed tax credit	Heritage Foundation	Market forces: comparison shopping by individuals
Managed competition	Employers would have to offer —and workers would have to join—one of several comprehensive, accountable health plans	Jackson Hole Group of health industry experts and executives	Market forces: comparison shopping by individuals from plans screened by employers or other intermediaries

up in some doctors' offices. The foundation, supported mainly by private grants, is the main vehicle for informing patients about outcomes research, which Wennberg believes should be disseminated promptly. Another innovation is the interactive videodisk format. This allows the patient, by pointing a mouse or touching a screen menu, to get information tailored to his or her symptoms and to skip or repeat.

Informed by watching the program, the patient is able to participate in what Wennberg calls "the shared-decision model." His premise is that in many nonemergency situations, the course of action should reflect the patient's preferences as well as the doctor's leanings. "Several very good studies," says the narrator of the forthcoming videodisk on early breast cancer, show that mastectomy and breast-sparing surgery combined with radiation "offer an equal chance of survival." But, she adds, "making the best choice involves deciding what *you* feel is important or acceptable." Women who chose the different options come on screen and explain why they're glad they did.

With low back pain, only the victim who feels it can decide whether a drastic remedy is called for. The narrator of this program is Dr. Albert Mulley Jr., chief of general internal medicine at Massachusetts General Hospital and a longtime Wennberg collaborator. Mulley begins by saying, "There are no simple and quick fixes for back pain. But there are many treatment options." For a herniated disk, the most common cause of back pain, the choices are various kinds of surgery and nonsurgical therapy.

"The problem usually gets better without surgery," Mulley says. A man who decided against it appears. "I think my future is looking brighter and brighter every day," he says. Not so a woman who felt she could not live another day without an operation: "I couldn't get up. I couldn't move. All I remember is being unable to function at all."

If surgery appears unavoidable, Mulley says, "the best evidence suggests that fusion is rarely necessary or helpful for people whose main problem is a herniated disk." Viewers inclined toward nonsurgical therapy can get information on anti-inflammatory medication and exercise. "It is possible to enjoy sexual activity even with back problems," the videodisk reports, offering sketches of suggested positions for those who want to see them.

Panels of physicians review the videodisks to ensure that they present the information fairly. "We want to bootstrap our way to 25 or 30 programs in the next three years," says Joseph Kasper, the producing foundation's CEO. Blue Cross is so intrigued by the prostate program that it plans a test in which it would pay doctors and medical groups $50 for each showing in lieu of a costlier second opinion. "Actually," says Kasper, "the disk *is* a second opinion—the patient's."

A videodisk expected late this year on low back pain will educate patients so they needn't be cowed into agreeing to surgery.

■ **Do it right.** The secret is out. The emphasis on quality is not uniform throughout the medical system. Mortality rates between hospitals, and individual surgeons, vary a lot even allowing for the severity of the case mix. Continuous quality improvement—doing it for less *and* doing it better—is now the hot concept in the better-run parts of the health industry. In pursuing it, providers are relying heavily on what the industry has long avoided except for sending out bills—the computer.

To see the future, visit the Harvard Community Health Plan's stunning new outpatient center in Burlington, Massachusetts. It's the first of many centers that will use software developed by InterPractice Systems, jointly owned by the HMO and GM's Electronic Data Systems. By pointing and clicking at a computer screen, the doctor can call up your records and interrogate them. How many times have you previously been in for an ear infection? With another click, the doctor can order pills that will be ready within three minutes at the center's pharmacy in a bottle with a computer-printed label—but only if the electronic record knows of no allergies or other reasons why you shouldn't take them.

Dr. Max Walten, 53, a pediatrician and longtime technophobe, needed 24 hours of training to master the computer. Now he loves it. "I don't have to put up with a partner's illegible handwriting or missing charts," he says. Down the road, computers could save considerable physician time. A hundred terminals have been installed experimentally in Burlington homes, where people who are not feeling well can explain their symptoms by answering questions that appear on a screen. If the symptoms are serious, the computer will arrange for a doctor to telephone or will tell the staff to schedule an appointment. But if the patient has a common cold, it will tell him how to treat it himself, eliminating some of the 25% to 44% of office visits that are medically unnecessary.

Quality is an obsession at Intermountain Health Care (IHC) of Salt Lake City, a chain of hospitals divested by the Mormon Church in 1975. Dr. Brent James, executive director of IHC's Institute for Health Care Delivery Research, peppers his talk with names like quality guru Philip Crosby and terms like "benchmarking." The chain zealously measures quality deviations and cajoles physicians to eliminate them. James asserts that 25% to 35% of health expenditures are "quality waste," which means fixing things because you couldn't do it right the first time.

To reduce deep-wound infections following surgery, which typically add $14,000 to a hospital bill and sometimes kill people, IHC turned to its bedside HELP computer. Developed over two decades and incorporating expert systems, it is marketed by 3M. With HELP's help, researchers at the chain's flagship LDS Hospital figured out an optimum time to administer antibiotics

before elective surgery, and the computer now alerts the staff at the right moment. Result: The postoperative infection rate fell in one year from 1.8% to 0.9%, less than half the national average, and has since dropped to 0.4%.

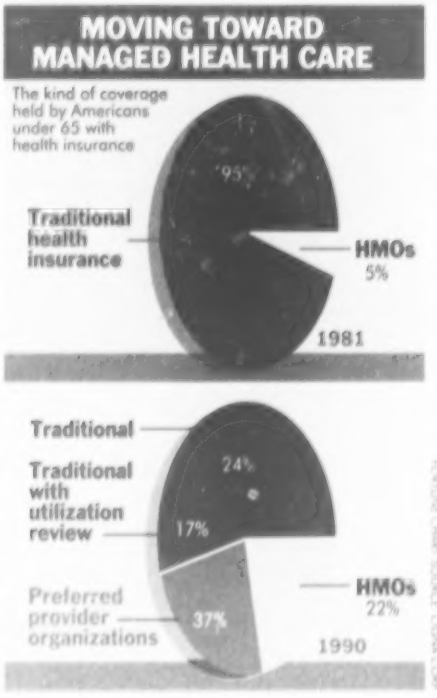
In an intensive care unit, computers have unusual potential to save lives. Hundreds of variables must be continually evaluated when a patient is brought in with adult respiratory distress syndrome (ARDS), which results when the lungs fill with water as a result, say, of a severe injury or pneumonia. Dr. Alan Morris, director of research at LDS Hospital's pulmonary division, says it's a daunting task for "a mere mortal" to assimilate all these variables, such as various blood gases and breathing characteristics, and keep making the right clinical decisions. The normal treatment is to force oxygen into a patient's lungs with a mechanical ventilator. In severe ARDS cases, only about 12% leave the hospital alive.

Deciding to substitute consensus for imprecise judgment, a committee labored two years to develop an elaborate ARDS treatment protocol with 35 pages of flow diagrams. These were put into HELP, which speedily reacts to changes in variables by issuing a stream of new instructions, such as "change oxygen content from 50% to 60%." Physicians sometimes have reasons to override the protocol, but compliance is high. The biggest surprise is a more than threefold increase in the survival rate for victims with severe ARDS, to 42%.

Until a randomized trial of the computer protocol is completed at a hospital in another state, Morris hesitates to proclaim a breakthrough. But on the basis of its success, LDS has already decided to keep using the ventilator instead of switching to an expensive, highly touted Italian heart-lung machine, which saved no more lives when it was tested against the older device.

■ **Unleash incentives.** Not all hospital chains have IHC's dedication to quality care at reasonable prices, which just happens to dovetail with its determination to hang on to its market share in the areas it serves. "We compete like mad," says James. HMOs have built-in incentives to watch costs. Thus, it is no accident that these prepaid plans, including Group Health Cooperative of Puget Sound as well as Kaiser Permanente, have welcomed the chance to show a prostate video that deters excessive surgery.

Eliminating the unnecessary is a way of life at Kaiser, America's biggest HMO. The plan's Denver region has found that 34% of people who get uncomplicated appendectomies—those who recover quickly and don't need shots for pain control—can be sent home within 24 hours. Kaiser's Southern California region plans to gradually build a data system costing $100 million or so that will enhance its ability to weigh the cost-effectiveness of procedures. The possibilities, says Eddy, who serves as a consultant, are "fabulous." While avoiding waste, Kaiser doesn't slight quality. Its San Francisco hospital is one of the safest places in California to have a coronary bypass.



Traditional fee-for-service health insurance, increasingly subject to scrutiny, is losing ground to tightly managed HMOs and preferred-provider organizations that offer discounted fees.

These examples of good incentives at work, alas, are overwhelmed by the perverse forces that keep pushing up the nation's health bill. The market can't get the situation under control, says the National Leadership Coalition for Health Care Reform, a nonpartisan group whose members include corporations, unions, health care professionals, and consumers. Under the coalition's play-or-pay health proposal, a board with government and private members would set a national spending target and establish uniform rates for services in order to slow the growth in health care spending to that of the GNP.

One of the troubles with expenditure targets, says Bernard Tresnowski, president of the Blue Cross & Blue Shield Association, is that "there's no infrastructure in place" to enforce them. Besides, market forces have already been shown to work. Newsletter editor Boyles says that the average HMO premium, smaller to begin with, will increase 11% in 1992, compared with 18% for fee-for-service plans. HMOs, whose total membership has quadrupled in the past decade to 38 million, exert some downward pull on prices when they reach a significant percentage of the market. Despite that salutary effect, HMOs and their kin won't ever hold total U.S. health spending in check as long as traditional insurance prevails.

What's needed is a system that combines increased competition among health care plans with greater incentives for individuals to seek one that minimizes the effect on their pocketbooks. One solution, proffered by the Heritage Foundation, a conservative Washington, D.C., think tank, would be to hand citizens money in the form of government tax credits and then turn them loose to comparison-shop for the best coverage.

The trouble with that kind of system, says Alain Enthoven, a professor at the Stanford business school and one of the leading experts on health care policy, is that "naked, unaided consumers" are unable to absorb the fine print in a welter of differing plans. Some insurers, he adds, are all too adept at "risk selection," or fashioning their policies to attract the young and healthy while avoiding the old and sick. Enthoven favors a much more structured approach, which he calls "managed competition." He would rely on sophisticated intermediaries, such as a FORTUNE 500 company buying for its employees, to winnow the offerings to a handful of deserving choices.

Managed competition is one of the key principles of an ambitious blueprint for reform that has emerged from two years of Wyoming meetings by a group of health care experts and executives. With the Tetons as a backdrop, what's known as the Jackson Hole Group has come up with a set of proposed policies called "The 21st Century American Health System."

Under the proposals, which Enthoven helped draft along with Ellwood of InterStudy and Lynn Etheredge, a Washington health care consultant, the federal govern-

ment would narrow the variation in health plans by putting conditions on the tax exclusion employees now get for employer-paid insurance premiums. At present this tax break, which costs the U.S. Treasury $48 billion a year, comes with no strings attached. "It's insane," says Etheredge. "The government is pouring out that money mainly to subsidize insurers who write blank checks."

"The government is pouring out money to subsidize insurers who write blank checks."

If the Jackson Hole Group had its way, the tax break would be available only for services provided by "accountable health partnerships," a term for HMO-like networks and others able to prove their ability to control costs and provide quality care. Moreover, the exclusion would cover only a package of "uniform effective health benefits"—those deemed part of essential coverage and known to work. Small companies would get the same rates as big corporations by buying jointly through newly created "health insurance purchasing corporations."

The beauty of the Jackson Hole plan is that it calls for no big new government spending program. Money saved by capping the tax exclusion would help subsidize coverage for the uninsured and the unemployed, which could be provided within a few years. Most of the needed regulation would take place outside government. Acting on their own, or in response to federal legislation if a prod were needed, consumers, insurers, health care providers, and employers would create three standards-setting boards. The boards would issue ground rules for insurers, assess the medical arts to determine annually what goes into the package of "uniform effective health benefits," and establish "generally accepted practices" for tracking the results of medical care.

Only one new government agency would be needed, a National Health Board that would register health partnerships that follow the "generally accepted practices." It would also oversee the industry panel that sets health accountability standards, much as the SEC looks over the shoulders of the Financial Accounting Standards Board.

This blueprint is miles beyond what's proposed in the new health plan of the Bush Administration, which rejected the idea of limiting the tax break as too controversial in an election year. While calling for the enrollment of more Medicare and Medicaid beneficiaries in prepaid plans, the Bush proposal would allow a large amount of wastefully run health care to continue in the private sector.

Jackson Hole would put virtually the entire population in accountable, cost-constrained plans. The entire set of reforms would take about a decade, though many of the changes could occur incrementally. And if you live in an area where good HMOs are scarce, don't worry; a forced march toward managed competition would provide growth opportunities for HMOs that measure up.

Until an ideal system is created, business can do a lot more than wail about soaring health benefits. Heads of big companies, who have passed up the chance to participate in forums like Jackson Hole, can climb aboard the reform bandwagon. When it comes to health care, says Ellwood, "there's no CEO spokesperson for business and no consensus among business people." The top brass pay scant attention even to their own company programs. A typical benefits manager rarely sees the CEO, says Joseph Duva, who focuses on managed health care as a partner with Ernst & Young. When he does, "he has to talk in sound bites."

On health care, says an expert, "there's no CEO spokesperson for business."

Companies are banding together in a few cities to query hospitals on outcomes and quality, in the hope of getting more value for all the money they are spending. In a precedent-setting effort at the national level, a consortium of 11 corporations—among them General Electric, AT&T, Procter & Gamble, and Marriott—is going beyond mere bill paying to delve into the way health care is provided. Working with insurers, HMOs, and the IHC hospital chain, the companies are conducting a six-month pilot study to see what can be learned from data on patients with asthma and angina, the chest pain that can lead to a coronary bypass. If the pilot is successful, says William Goss, head of managed-care programs at GE, a full-scale effort will follow. In the case of asthma, he says, the consortium hopes to answer such questions as "How can we build a better protocol?" and "How can we catch the symptoms sooner?"

MERELY BY SPENDING their health care dollars creatively, companies can nudge the system into the future as Xerox is doing. In addition to traditional insurance plans, the company tries to offer at least two good HMOs at every major employment site, and has engaged six HMO companies to do "hands-on, close-up evaluation" of what's available.

To put meaning in comparison shopping, Xerox gears its contributions to a "benchmark" HMO whose price is the lowest consistent with quality. For employees who pick this HMO, the company pays all but $12 a month for a family. If an employee picks a plan costing, say, $75 a month more, he bears the entire extra cost. So far, the percentage of Xerox employees in HMOs has risen to 59%, and benefits director Patricia Nazemetz says there's been a "migration" toward the lower-price plans. The pricing policy is based on a similar one at Stanford University, where Enthoven runs the health program. Competition goes on at two levels—the employer shopping for HMOs and the employee choosing from the narrowed menu.

That's far preferable to the dubious path some companies are taking, which is to corral all workers into one health plan. Under that approach, says Dr. David Lawrence, CEO of the Kaiser plan's parent foundation, "a single provider is able to hold the company hostage." It takes alternatives to keep HMOs efficient—and caring—and a "point of service" option, which allows employees to see doctors outside the network, should not be the only escape hatch. Once a year, those who are dissatisfied should be able to switch to another plan. If market forces are to work in health care, fear is essential—the fear that the customer might take his business elsewhere. F